My New Home in the Community

An Information Handbook for
Individuals and Families
Preparing to Transition from Institutions
to New Homes in the Community

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DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

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Introduction

What is the *My New Home in the Community Handbook* and how do I use it?

This *Handbook* was designed to provide practical information to individuals who are preparing to transition from training centers to new homes in the community. Getting ready to move to a new home can be exciting and scary at the same time.

This *Handbook* is written in a format that is easy to follow in order to help you and your family understand the transition process and make the most of moving to your new home. This *Handbook* has a lot of information and it may cause you to have additional questions. You should feel free to ask someone for assistance in getting your questions answered. See pages 26 - 27 for contact information for the Department of Behavioral Health and Developmental Services (DBHDS) Family Resource Consultant or your local Community Resource Consultant.

What is the Department of Justice (DOJ) Settlement Agreement?

In 2008, the Department of Justice (DOJ) began an investigation of Central Virginia Training Center (CVTC) according to the Civil Rights of Institutionalized Persons Act (CRIPA). The investigation was expanded to cover Virginia's whole system of services for individuals with intellectual and developmental disabilities, including all five state training centers and community based services.

DOJ issued a findings letter to Governor McDonnell in 2011 concluding that Virginia is not providing services in the most integrated and appropriate setting, not developing a sufficient quantity of community services, and that Virginia has a flawed discharge process at training centers. Virginia then began good-faith negotiations to reach a settlement agreement with DOJ while not subjecting the Commonwealth to a costly and lengthy legal battle.

In 2012, Virginia and DOJ reached a settlement agreement. This agreement will ultimately provide the necessary services so more individuals with intellectual and developmental disabilities can live successfully in their home communities and it will lead to a more effective use of public funds.

In March of 2012, Judge John A. Gibney signed a temporary order for approval of the settlement agreement. In August 2012, Judge John A. Gibney signed the permanent order for approval of the settlement agreement.

How will the DOJ Settlement Agreement affect individuals living in training centers?

The settlement agreement targets individuals with a developmental disability who meet any of the following additional criteria: (1) currently live at any of the training centers, (2) meet the

criteria for the Intellectual Disability (ID) waiver or Developmental Disability (DD) waiver wait lists, or (3) currently live in a nursing home or ICF.

Discharge plans will be developed for all individuals in training centers using a documented person centered planning and implementation process. The plan will be an individualized support plan for transition into the community.

DBHDS will ensure that the personal support teams, working with the CSB case manager, provide individuals and their authorized representatives with specific options for types of community placements, services and supports based on the individual's needs and desires.

Virginia will move forward with plans to cease residential operations at four of Virginia's training centers. The following timeline has been established for closures: Southside Virginia Training Center (SVTC) in 2014, Northern Virginia Training Center (NVTC) in 2015, Southwestern Virginia Training Center (SWVTC) in 2018 and Central Virginia Training Center (CVTC) in 2020. Southeastern Virginia Training Center (SEVTC) will remain open with 75 beds.

What do you mean by "community?"

Lots of people feel that their community is wherever they live. For the purposes of this *Handbook*, "community" will mean a place to live where there are only a few people in each house and there are places to go and things to do right near your home.

How will my person-centered plan work in the community?

Your person-centered plan will continue to work just like it does in the training center. You and your team will develop a plan that helps you define the direction of your own life. Your plan will allow you to look towards the future to discover and share your goals for a better life in the community.

Your gifts, talents, goals, preferences, needs and choices will be in the center of the planning process.

Your plan will help you to state what is truly important to and for you. This includes family, friends and paid professionals. It also includes what you will need in order to stay healthy, safe and valued in your new community.

Listening to you and the people who know you best will be a key factor to the success of your person-centered plan. Those who know you best can share the best ways to communicate with you in order to ensure your valuable input in future planning. This will allow your idea or vision of a good life to be transformed into an action plan.

Finally, your person-centered plan will help you find people in your community to support you on your journey. Your support network will include family, friends and professionals that best support you and will follow through on your action plans throughout your journey. Your life will be enriched by community connections and opportunities to contribute and receive support as you transition to your new home in the community.

Can I choose where I want to live?

YES! Choice of where you live is the most important part of your transition. Case managers, transition coordinators, facility and other staff do not decide where you will live. They will provide you with information and help, but in the end it is YOUR decision.

What kind of homes can I choose from?

You have lots of choices of home types. We will discuss in detail on the following pages the types of homes, how you can qualify to live there, and what a provider must do to support you in your new home.

<u>You are strongly encouraged</u> to research, visit, and evaluate any home you are considering before you make the decision to move there.

Community Living Options

First of all, you can choose to ***live at home with your parents or other family members*** you are close to. You must talk with them and decide if this is the best option for you and them and agree on the types of supports you will need to successfully live there.

You can also choose to **move to a home or apartment that you or your family member owns or rents.** If this is an option that sounds good to you, you must decide with your family member if this is the best option for you and agree on the types of supports you will need to live there successfully.

If either of the above options is chosen, the following service might be helpful to you:

In-home Residential Services

What are in-home residential services?

In-home residential services are typically provided in a private home and are in addition to the primary care provided by the individual, caregiver(s) or family member(s). In-home supports may not be in place of this primary care. These supports help individuals to improve or maintain their health/medical status while living at home, enable individuals to use the community, improve their abilities, gain new home living or community skills and act safely and appropriately in their community.

How do I qualify?

If you are eligible for and enroll in the Intellectual Disability Waiver, you may receive in-home residential services.

What are the limitations?

In-home residential services are delivered on an individualized basis. The supports are typically for less than a continuous 24 hours, according to the Plan for Supports (PFS) and are delivered primarily with a 1:1 staff-to-individual ratio (exceptions may apply). In-home supports are reimbursed on an hourly basis for the time the residential staff is working directly with the individual.

What are the provider requirements?

An agency must be licensed by the DBHDS as a provider of supportive residential services and have a provider agreement with DMAS.
Provider staff must receive training through the "Orientation Manual for Direct Support Professionals".

Residential support providers may not be the parents of individuals who are minors or the individual's spouse.

The following choices include living in a home with people who are not related to you:

Sponsored Residential Services

What are sponsored residential services?

Sponsored residential services are supports provided in a person's or family's ("sponsor's") home. The sponsor is evaluated, trained, supported and supervised by a provider agency that follows the rules for licensing by DBHDS.

How do I qualify?

If you qualify for and enroll in the Intellectual Disability Waiver (see page 14), you may move to a home with a "sponsor" family, who will give you residential supports. To qualify for this Waiver you must be eligible for Medicaid, meet the Level of Functioning Survey criteria and have a diagnosis of intellectual disability.

What are the limitations?

Only two people may receive sponsored residential services in one home.

What are the provider requirements?

Physical location: All sponsor homes must meet certain rules. The physical environment, design, structure, furnishing, and lighting of the home must be safe and appropriate for you and include:

- Clean floor surfaces and floor coverings that enable you to move safely;
- Adequate ventilation and temperatures kept between 65°F and 80°F;
- Adequate hot and cold running water of a safe and appropriate temperature;
- Sufficient interior and exterior lighting to maintain safety; and
- Recycling, composting, and garbage disposal that do not create a nuisance, permit transmission of disease, or create a breeding place for insects or rodents.

Bedrooms for one person can have no less than 80 square feet of floor space. Bedrooms for more than one person can have no less than 60 square feet of floor space per individual. You must have enough storage space for your clothes and personal things. The beds must be clean, comfortable and have a mattress, pillow, blankets, and bed linens. When a bed is soiled, the sponsor must assist you with bathing as needed, and provide clean clothing and bed linen. Bedroom and bathroom windows and doors must provide privacy. No one should have to travel through another bedroom to get to the bathroom. There must be at least one toilet, one hand sink, and shower or bath for every four individuals. A well-stocked first aid kit must be maintained and readily accessible for minor injuries and medical emergencies that can be used by employees or contractors providing in-home services or traveling with individuals.

Provider agency responsibilities: The DBHDS licensed provider agency must maintain a written agreement with residential home sponsors and provide training and development opportunities for sponsors to enable them to perform the responsibilities of their job. The provider is required to maintain an organized system to manage and protect the confidentiality of personnel files and records.

The provider agency must keep information on file about the sponsor(s) such as:

- Documentation of references;
- Criminal background checks and results of the search of the registry of founded complaints of child abuse and neglect on all adults who are staff in the home;
- Orientation and training (including ID Waiver required training using the “Orientation Manual for Direct Support Professionals”) provided to the sponsor; and
- A log of visits made to the sponsor’s home. These visits must occur on an unannounced basis at least semi-annually.

The licensed provider agency must identify your physical, medical, behavioral, functional, and social strengths, preferences and needs, as applicable. Using this information, the provider must then develop an individualized services plan. A responsible adult must be available to provide supports as specified in the individualized person-centered service plan.

Both the licensed provider and the sponsor are required to comply with DBHDS human rights regulations.

If behavioral intervention (also known as behavioral management) procedures are to be used, they must:

- Be consistent with applicable federal and state laws and regulations;
- Emphasize positive approaches to behavioral intervention;
- List and define behavioral intervention techniques in the order of their relative degree of intrusiveness or restrictiveness and the conditions under which they may be used for you;
- Protect your safety and well-being at all times, including during fire and other emergencies;
- Specify the mechanism for monitoring the use of behavioral intervention techniques; and
- Specify the methods for documenting the use of behavioral intervention techniques.

The provider agency must develop and deliver periodic emergency preparedness and response training for all sponsors and their employees. There must be at least one person at the home who holds a current standard first aid and cardiopulmonary resuscitation certificate, in or has emergency medical training. Each sponsor or employee who will have direct contact with the individual must obtain a statement from a medical professional indicating the absence of tuberculosis in a communicable form within 30 days of employment or contact with individuals.

The provider agency is required to maintain the following emergency medical information about each individual:

- If available, the name, address, and telephone number of:
  - ✓ The physician; and
  - ✓ A relative, surrogate decision maker (for example, an authorized representative), or other person to be notified;
- Medical insurance company name and policy or Medicaid, Medicare or CHAMPUS number, if any;
- Currently prescribed medications and over-the-counter medications that you use;
- Medication and food allergies;
- History of substance abuse;
- Significant medical problems;
- Significant communication problems; and
- An advance directive, if one exists.

Medications can be administered only by persons authorized by state law.

The provider agency ensures a means for providing or arranging, as appropriate, your transportation to medical and dental appointments and medical tests. Any member of the sponsor family who transports you must have a valid driver's license and automobile liability insurance. The vehicle used to transport you must have a valid registration and inspection sticker.

Sponsor(s) responsibilities: Sponsored residential home members must submit to the provider agency the results of a physical and mental health examination when requested by the provider based on indications of a physical or mental health problem.

The sponsor must have a written plan for the provision of food services, which ensures access to nourishing, well-balanced, healthful meals. In addition, the sponsor must make reasonable efforts to prepare meals that consider cultural background, personal preferences, and food habits and that meet dietary needs. The sponsor must assist individuals that require assistance in feeding.

The sponsor must provide opportunities for you to participate in community activities.

Group Home Residential Services

What are group home residential services?

Group home residential services provide 24-hour supervision to several individuals at the same time from the same staff in a community-based home operated by a provider agency licensed by DBHDS. Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions (ICFs/ID) are not considered to be group home residential services.

How do I qualify?

If you are eligible for and enroll in the Intellectual Disability Waiver, you may receive group home residential services as your means of residential support.

What are the limitations?

Usually there are no limitations for the group home size you select. For the Money Follows the Person (MFP) Project (pages 17 & 18), you have to choose “a qualified residential setting,” one of which is a group home that has no more than four people living in the house.

What are the provider requirements?

The provider agency requirements are essentially the same as those listed under sponsored residential services. However, the licensed provider hires direct support professionals to work in the group home instead of contracting with sponsor(s) to provide services in their own home. Therefore, responsibilities of the sponsor become the responsibilities of the provider agency.

Community ICF/ID Home

What is a Community ICF/ID home?

Community Intermediate Care Facilities for Persons with Intellectual Disability (ICF/ID) homes are another example of residential services providing 24-hour supervision to individuals in a community-based dwelling operated by a provider agency. Community ICF/ID homes provide health or rehabilitative services and provide “active treatment” to individuals receiving services toward the achievement of a more independent level of functioning or an improved quality of life.

How is this different from a regular group home?

A community ICF/ID home is different because it provides more intensive training and supervision than may be available in an assisted living facility or group home. ICF/ID homes typically provide services to four to twelve individuals in a larger setting. Community ICF/ID homes are licensed by the DBHDS, but also certified for Medicaid by the Department of Health, and Office of Licensing and Certification.

How do I qualify?

You must be eligible for Medicaid, meet the Level of Functioning Survey criteria and have a diagnosis of intellectual disability.

What are the limitations?

If you choose this option, you may have fewer choices about the providers of various services, as the ICF/ID provides or contracts directly for all the services the individual requires.

What are the provider requirements?

Providers must follow both the federal ICF/ID and Life Safety Code requirements. The Virginia Department of Health (VDH), through the Office of Licensure and Certification, is the state agency responsible for assessing compliance with federal ICF/ID program participation requirements. VDH contracts with the Virginia Department of Fire Program's State Fire Marshal's Office (SFMO) to determine compliance with the federal Life Safety Code requirements.

Micro-board

What is a Micro-board?

A micro-board is a non-profit group made up of family and friends that act as surrogate parents for an adult with an intellectual disability. The micro-board purchases a house that will be used as a home for several individuals who will share the common living environment (such as kitchen, living room, dining room, and bathroom), but in which each individual has a private bedroom.

How will creating a micro-board benefit me?

A micro-board brings together a dedicated group of people committed to the individual to assist him/her accomplish personal life goals. The idea of housing owned by a micro-board grew out of federal initiatives to increase self-sufficiency by allowing Medicaid waivers to provide supportive services in a residential setting. Micro-boards continue to offer independence and community integration to individuals with disabilities.

Where can I find more information about micro-boards?

This concept is very complex; therefore, it is important to research micro-boards to see if this type of mortgage will be an option for your family. There is a wealth of information on the internet regarding micro-boards. The Virginia Development Housing Authority (VHDA) has also developed broad, flexible programs such as micro-boards that offer funding to increase affordable housing opportunities for people with disabilities. In addition to providing financing, VHDA helps to educate parents, families and friends regarding applying for nonprofit status, Medicaid waivers, and how to proactively work with Centers for Independent Living and Community Service Boards. Visit VHDA's website to learn more about their housing programs @ www.vhda.virginia.gov.

What will I do During the Day?

Your person-centered individualized support plan will continue to meet your needs and preferences. If you choose to have a daily routine, the following services which are currently funded under your ICF/ID (training center) will continue to be funded under the ID waiver:

Supported Employment

Supported employment services help you develop your job skills in places in which persons without disabilities are typically employed. There are two types of models: individual supported employment, in which you get 1:1 help from a job coach, and group supported employment, in which you work with a group of other people and are helped by a job coach.

Prevocational Services

Prevocational services are services aimed at preparing you for paid employment or volunteer work, but which are not about learning specific job tasks. Prevocational services may take place in a "center" or in places around the community.

Day Support Services

Day support services include building or maintaining your skills in the areas of self-help, socialization, community integration and adaptive skills. Day support provides opportunities for interacting with your peers, participating in activities in your community and making new friends.

What if I Need Medical Help Throughout the Day?

Skilled nursing services are available to individuals with serious medical conditions and complex health care needs. These services are ordered by a doctor. Some things that a nurse can do are: monitor your medical status, administer medications and other medical treatment or train, consult with, delegate certain tasks to or oversee family members, staff and other persons responsible for carrying out your ISP. Services must be provided by a registered nurse (RN) or licensed practical nurse (LPN) under the supervision of a RN.

Waiver Options

What is a Medicaid Home and Community-Based Waiver?

A “waiver” is a way for the State Medicaid program to pay for your services in the community. States make applications for Medicaid Waivers with the federal Medicaid agency, known as the Centers for Medicare and Medicaid Services (CMS). This enables states to waive the usual requirements that individuals must live in an institution in order to receive Medicaid funding for services. In this way, Medicaid funds certain community-based alternatives to institutional care.

In order to receive ID Waiver services, you must meet eligibility requirements and a “slot” must be available. You are found eligible for ID Waiver services based on three factors:

Diagnostic Eligibility: Individuals six years of age or older must have a psychological evaluation completed by a licensed professional that states a diagnosis of intellectual disability and reflects the individual’s current level of functioning. Individuals under age six must have a psychological or standardized developmental evaluation that states that the child has a diagnosis of intellectual disability or is at developmental risk and reflects the child’s current level of functioning.

Functional Eligibility: All individuals receiving ID Waiver services must meet the ICF/ID level of care. This is established by meeting the indicated dependency level in two or more of the categories on the “Level of Functioning Survey,” which is completed by the CSB support coordinator/case manager.

Financial Eligibility: An eligibility worker from the local Department of Social Services determines an individual’s financial eligibility for Medicaid. Some individuals who would not ordinarily qualify financially for Medicaid may be eligible because they receive ID Waiver services.

It is important to remember in order to qualify for a home and community based waiver you must choose to live in the community, not in an ICF/ID. Currently Virginia’s ID waiver provides eighteen different services.

What Medicaid Waiver is right for me?

Virginia has six different Medicaid waivers. Each waiver has certain criteria for participating. Because of your disability and the type of services you most likely need, you will be eligible for the Intellectual Disability Home and Community Based Waiver. Most people know this as the ID Waiver.

What services are covered under the ID Waiver?

The ID Waiver has many services to support you after transitioning to the community. The following services are available to individuals meeting the specific service criteria who have been assigned an ID Waiver slot:

- Assistive Technology
- Companion (agency or consumer directed)
- Crisis Stabilization
- Day Support
- Environmental Modifications

- Personal Assistance (agency or consumer directed)
- Personal Emergency Response Systems (PERS)
- Prevocational Services
- Residential Support Services
- Respite (agency or consumer directed)
- Services Facilitation (SF)
- Skilled Nursing Services
- Supported Employment
- Therapeutic Consultation
- Transition Services

While there is a waiting list for the ID Waiver, the Department of Medical Assistance Services (DMAS) has set aside slots that will only be available for individuals transitioning from all training centers and for individuals choosing to participate in the Money Follows the Person Project (MFP). See pages 17 & 18 for more information about MFP.

How do I access ID Waiver services?

An individual, family or representative requests services from the local CSB/BHA.

The support coordinator/case manager determines the preferred services and necessary supports by meeting with you and your family (or other caregivers). He/she also confirms diagnostic and functional eligibility by obtaining a psychological evaluation and completing a Level of Functioning Survey (LOF).

Once you are determined eligible (including financial eligibility through the Department of Social Services), the support coordinator/case manager informs you and your family of the full array of ID Waiver services and documents your choice of Waiver or institutional care.

If you select the ID Waiver, the support coordinator/case manager submits required enrollment information to the DBHDS Office of Developmental Services (ODS).

Once you have been enrolled in a Waiver slot, you and your family choose providers for needed services. The support coordinator/case manager coordinates the development of your Person-Centered Individual Support Plan (PC ISP) with you, your family or other caregivers and your chosen service providers within 30 days of enrollment. The PC-ISP includes all of the individual Plans for Supports (PFS) developed by this team and describes the services that will be provided.

Before the start of services, the support coordinator/case manager sends appropriate documentation to ODS staff for review and authorization of the requested ID Waiver services.

Once approved, ODS staff enters service data in the DMAS computer system. This automatically sends a letter to you and your chosen providers saying that you have been approved. This tells your providers that they can serve you and bill Medicaid for your services. Service provision should begin within 60 days from enrollment.

What other Medicaid benefits and services may be available?

You may also be eligible for the following Medicaid State Plan services offered in Virginia:

1. Mandatory State Plan Services

As with all state Medicaid programs, certain services provided by Virginia's program are required by the federal government. These are:

- Inpatient Hospital Services
- Emergency Hospital Services
- Outpatient Hospital Services
- Nursing Facility Care
- Rural Health Clinic Services
- Federally Qualified Health Center Clinic Services
- Laboratory and X-ray Services
- Physician Services
- Home Health Services: Nurse, Aide, Supplies and Treatment Services
- Early and Periodic Screening, Diagnostic and Treatment Services (for those under 21 years of age)
- Family Planning Services and Supplies
- Nurse-Midwife Services
- Medicare Premiums: Hospital Insurance (Part A)
- Medicare Premiums: Supplemental Medical Insurance (Part B) for the Categorically Needy
- Transportation Services

2. Optional State Plan Services

In addition to the required service categories above, Virginia provides services in the following major optional categories:

- Other Clinic Services (in other words, services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics and local health departments)
- Skilled Nursing Facility Services for Individuals Under 21 Years of Age
- Podiatrist Services
- Optometrist Services
- Clinical Psychologist Services
- Certified Pediatric Nurse and Family Nurse Practitioner Services
- Home Health Services: Physical Therapy, Occupational Therapy and Speech Therapy
- Dental Services for Individuals Under 21 Years of Age
- Physical Therapy and Related Services
- Prescribed Drugs
- Targeted Case Management Services
- Prosthetic Devices
- Mental Health Services, including intensive in-home services for children and adolescents, therapeutic day treatment for children and adolescents, community-based residential treatment for children and adolescents, day treatment/partial hospitalization, psychosocial rehabilitation, crisis intervention and targeted case management
- Mental Health Clinic Services

- Hospice Services
- Medicare Premiums: Supplemental Medical Insurance (Part B) for the Medically Needy
- Nutritional supplements for those for whom they are the sole source of nutrition.

Money Follows the Person (MFP) Project

What is the Money Follows the Person (MFP) Project?

Money Follows the Person (MFP) gives individuals of all ages and all disabilities who live in institutions in Virginia new options for community living. No age or disability is excluded from participation. This Project has three major goals:

Goal 1: To give individuals who live in nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities and Related Conditions, and long-stay hospitals more informed choices and options about where they live and receive services.

Goal 2: To transition individuals from these institutions if they choose to live in the community.

Goal 3: To promote quality care through services that are person-centered, appropriate, and based on individual needs.

What is some background information on MFP?

In 2008, Virginia launched Money Follows the Person (MFP) Demonstration Project to provide extra supports and services to Virginians who choose to transition from long-term care institutions into the community. Virginia is one of 45 states participating in MFP, funded by the Centers for Medicare and Medicaid Services through 2016. This project supports Virginia's Olmstead initiative. MFP is a joint effort between the Department of Medical Assistance Services, the Office of Community Integration, the Department of Behavioral Health and Developmental Services and other state agencies and stakeholders.

What must I do to qualify for MFP?

To participate in the MFP project, you must:

- Have lived for at least 90 consecutive days in a hospital, nursing facility (any days spent in short-term skilled rehabilitation services do not count towards the 90 days), ICF/ID, long-stay hospital, institute for mental disorders, psychiatric residential treatment facility, or a combination of these;

- Be a resident of the Commonwealth of Virginia;

- Have received Medicaid benefits for inpatient services for at least one day prior to MFP enrollment;

- Qualify for, and enroll into upon discharge, a Program for All-inclusive Care for the Elderly (PACE) **or** one of the four following waiver programs:
  - Elderly or Disabled with Consumer-Direction Waiver (EDCD)
  - Individual and Family Developmental Disabilities Support Waiver (DD)
  - Intellectual Disability Waiver (ID)
  - Technology Assisted Waiver (TECH);

- Move to a "qualified residence." A qualified residence is: (1) a home that you or your family member owns or leases; (2) an apartment with an individual lease, with lockable entry and exit, that includes living, sleeping, bathing and cooking areas over which you or your family has domain and control; or (3) a residence in a community-based residential setting in which no more than four (4) unrelated individuals reside.

What will happen to my "waiver" services after my 12 months of MFP participation end?

After participating for 12 months in the Project, you will continue to remain enrolled in the waiver as long as you continue to meet criteria for waiver eligibility.

How do I enroll in MFP?

The individual/guardian informs the current CSB support coordinator/case manager (if applicable) or institutional staff (discharge planner) of interest in enrolling in MFP.

How can I find out more about MFP?

You can learn about the MFP Project by contacting your support coordinator/case manager, the DBHDS Family Resource Consultant (contact information on page 27), or DMAS. Ask for *"The Money Follows the Person Project Guidebook."* You can also find this guidebook at the following website: http://www.olmsteadva.com/mfp/. This document has all of the details of the project to help you decide if you want to participate.

Systemic Therapeutic Assessment Respite Treatment (START)

What is Systemic Therapeutic Assessment Respite Treatment (START)?

VIRGINIA START is a systems-linkage approach to supports for individuals with an intellectual disability and/or developmental disability, and a mental health condition or challenging behavior that is negatively affecting their quality of life.

START emphasizes the prevention of crises before they occur. This is done through early identification of individuals, development of crisis response plans, training, and technical assistance. The underlying philosophy of START is that people's lives go better when everyone involved in supporting the individual work as a team to develop ideas and strategies that will work best for the person.

How will START support me after my transition?

START offers clinical assessment and support by using the following methods:

- Training and empowerment for individuals, families and caregivers;
- Mobile Crisis Units;
- 24/7 crisis line;
- Positive behavior supports;
- Therapeutic tools;
- Community and home based crisis intervention and stabilization supports;
- A planned therapeutic and respite facility for up to 6 adults; and
- Linking of community resources

Who is eligible for Virginia START?

Individuals age 18 and older with intellectual disability and/or a developmental disability as well as co-occurring behavioral health needs or challenging behaviors that are affecting their quality of life.

How do I make a referral to Virginia START?

See the contact information in your region below:

Charlottesville and Surrounding Areas
START Director - Kelly Watson
Kelly.watson@eastersealsucp.com (540) 259-1028
Jarret Stone, LCSW
Jarret.stone@eastersealsucp.com (919) 943-7585

Northern Virginia
START Director – Philippe Kane
Philippe.kane@eastersealsucp.com (571) 409-0377
Jarret Stone, LCSW

Jarret.stone@eastersealsucp.com (919) 943-7585

Southwest Virginia
START Director - Denise Hall, LCSW
info@swvastart.org (855) 88-START *(855) 887-8278* Fax: (540) 267-3403

Richmond and Surrounding Areas
START Director - Ron Lucas, LPC
lucasr@rbha.org (855) 282-1006

Southeast Virginia/Tidewater Area
START Director - Dona M. Sterling-Perdue, MSW
donas@hnncsb.org (855) 80-START *(855-807-8278)*

Virginia Department of Behavioral Health and Developmental Services
State Liaison: Bob Villa, Office of Developmental Services
Bob.villa@dbhds.virginia.gov (804) 371-4696

Rights and Guardianship

What are my rights?

You have all the rights afforded to you under the *Rules and Regulations to Assure the Rights of Individuals Receiving Services from Providers Licensed, Funded or Operated by DBHDS* (human rights regulations). These rights apply to you if you live at a training center or live and receive your services in the community.

Samples of these rights include:

- The right to participate meaningfully in the decision-making processes affecting your life and to have your wishes and preferences respected to the maximum extent possible. Participating meaningfully in decision making includes the right to give or not give consent. If you are not able to give any required consent, you have:
  - The right to have a representative make the decision for you. The representative is referred to as a "surrogate decision maker." You also have the right, if you are able, to participate in the selection of your surrogate decision maker.
- The right to freedom from abuse, neglect, and exploitation, domestic violence, and sexual assault, and the State makes every effort to prevent such occurrences. The local departments of social services provide ongoing education on the topic of adult and child abuse prevention to Virginia citizens, healthcare providers and others providing services to adults.
- The right to retain your legal rights as provided by state and federal law;

- The right to receive prompt evaluation and treatment or training about which you are informed to the best of your understanding;

- The right to be treated with dignity as a human being and be free from abuse and neglect;

- The right to be free from experimental or investigational research without your prior written and informed consent or that of your authorized representative.

- The right to be treated under the least restrictive conditions consistent with your condition and not be subjected to unnecessary physical restraint or isolation;

- The right to be allowed to send and receive sealed letter mail;

- The right to have access to your medical and service records and be assured of their confidentiality; and

- The right to participate in the development and implementation of your own individualized service plan.

If you or your family member believes your rights have been violated, a human rights advocate can be contacted. A listing of these advocates including their phone numbers can be found on page 27.

What is an authorized representative?

A person permitted by law or 12VAC35-115 to authorize the disclosure of information or consent to treatment and services or participation in human research.

What is a conservator?

A person appointed by a court to be responsible for managing the estate and financial affairs of an individual who is found to lack capacity to manage his or her own estate or financial affairs.

What is guardianship?

Guardians are individuals appointed by a court to protect an "incapacitated person."

An "incapacitated person" is a person who is unable to make decisions about his/her own care. It does not mean that he or she is "bad" or "foolish."

Only a judge can decide that a person is "incapacitated," and only a judge can appoint someone to be a guardian.

A "guardian" is someone who is totally in charge of another person's affairs.

Guardianship restricts the decisions that a person may make. Guardianship should be sought as a **last resort,** when there are no other options left. A guardian may be limited to making specific kinds of decisions, rather than all decisions, if the court decides the limits are appropriate.

What contacts does my guardian need to have with me regarding my plans to transition?

The approval of the guardian is required for the transition, and the guardian's continuous participation in decision-making is necessary. The guardian must maintain enough contact with you to know your capabilities, limitations, needs, and opportunities. Your guardian must visit you as often as necessary. Public guardians are expected to meet with you at least every three months, if not every month.

The guardian must, as much as possible, encourage you to participate in decisions, to act on your own behalf, and to develop or regain the capacity to manage your own personal affairs. In making decisions, the guardian must consider your expressed desires and personal values to the extent known and must act in your best interest and exercise reasonable care and caution.

How can I find out more information about guardianship?

Visit the VA Dept of Aging and Rehabilitative Services (DARS) @ www.dars.virginia.gov.

Monitoring and Oversight

I receive many supports and services at the training center. Will I receive the same supports and services in the community?

You and your family member or authorized representative (AR), along with your support coordinator/case manager will develop a person-centered service plan. This is a written plan of services addressing all life areas: physical and mental health; personal safety and behavior issues; financial, insurance, transportation, and other resources; home and daily living; education and vocation; leisure and recreation; relationships and social supports; legal issues and guardianship; and individual empowerment, advocacy, and volunteerism. Addressing all life areas, you, your family member or AR, and support coordinator/case manager will look at potential risks unique to you and determine what is needed to make sure you stay healthy, safe, and satisfied in the community, either through waiver services or through other sources. All of these services and supports will be specified in the plan and offered by the chosen providers. Each person-centered service plan will be updated and revised annually or when needed as things change in your life.

What is the Office of Licensing?

The DBHDS Office of Licensing licenses services providing treatment, training, support and habilitation to individuals who have mental illness, intellectual disability or substance abuse disorders. Licensing staff make at least one unannounced inspection of services per year and investigate complaints about licensed services.

What is the Office of Human Rights?

The DBHDS Office of Human Rights helps assure and protect the legal and human rights of individuals receiving services in facilities or programs operated, licensed or funded by the Department.

What monitoring does DMAS provide?

DMAS is the single state authority responsible for supervising the administration of home and community-based waivers in Virginia. DMAS performs routine "quality management reviews" (QMRs) of all waiver services and providers. These include a review of the provision of services to ensure that services are being provided according to DMAS regulations, policies, and procedures.

DMAS conducts QMRs of waiver services provided by all providers to ensure your health, safety, welfare, and your satisfaction with services. The reviews focus on areas required by the federal government such as making sure your individual service plan, includes your preferences, services are being delivered according to your ISP, that risks to you are identified and that you are being included in the community. In addition to assessing your ongoing need for Medicaid-funded long-term care, another purpose of the reviews is to ensure your satisfaction with services and providers and that your choice of services and the results of your person-centered planning are being carried out. This may involve interviews with you and/or your family/caregiver as appropriate.

Providers are continually monitored to make sure that they follow Medicaid participation standards and program policies. Providers are assessed on their ability to deliver consistent, high-quality supports.

DMAS's Provider Review Unit and Medicaid Fraud Control Unit provide further oversight by checking for individual and provider fraud. DMAS considers fraud to be an intentional deception with the knowledge that the deception could result in some unauthorized benefit to that or some other person.

For more detailed information regarding DMAS monitoring please visit the website at www.dmas.virginia.gov.

Who will be responsible for monitoring my transition (post-move monitoring)?

A number of staff from different agencies will be responsible for monitoring your services after you transition to the community. These include the following:

- Training Center staff
- Office of Licensing
- Office of Human Rights
- Office of Developmental Services Community Resource Consultants
- Community Services Board support coordinator/case manager

How often will staff from these offices provide monitoring?

See the post-move monitoring schedule below:

	3 day	7 day	10 day	17 day	1 mo	2 mo	3 mo	4 mo	5 mo	6 mo	7 mo	8 mo	9 mo	10 mo	11 mo	12 mo
TC	x		x	x												
OLS		x		x	x	x	x	x	x	x	x	x	x	x	x	x
CSB		x			x	x	x	x	x	x	x	x	x	x	x	x
CRC						x										
OHR					x											

Additional visits may occur based on needs of individual or provider.

TC = Training Center Staff
CSB = Community Services Board
OHR = Office of Human Rights
OLS = Office of Licensing
CRC = Community Resource Consultant

DBHDS Contact Information

Who is my Community Integration Manager?

Community Integration Managers (CIMs) are responsible for coordinating your discharge process from the training Center and ensuring that it occurs within a timely manner. There are five CIMs, one located at each training center to address your concerns or issues immediately.

Contact Information for Community Integration Managers (CIMs)

Jae Benz
Director of Training Center Discharges and Community Integration
DBHDS, Division of Developmental Services
1220 Bank Street
Richmond, VA 23218
Cell (804) 356-3664
Fax (804) 371-2308
jae.benz@dbhds.virginia.gov

CVTC
Beverly Littlejohn
Community Integration Manager
DBHDS, Division of Developmental Services
CVTC
521 Colony Road
Madison Height, Virginia 24572
Office (434) 947-6136
Fax (434) 947-2989
Beverly.Littlejohn@DBHDS.Virginia.gov

NVTC
Kelly Rinehimer
Community Integration Manager
DBHDS, Division of Developmental Services
NVTC
9901 Braddock Road
Fairfax, VA 22032
Office (703)323-4049
Cell (804)432-4795
Kelly.Rinehimer@DBHDS.Virginia.gov

SEVTC
Sarah K. Stansberry, M.S. Ed.
Community Integration Manager
DBHDS, Division of Developmental Services
SEVTC
2100 Steppingstone Square, Bldg. 1, Rm. 307
Chesapeake, VA 23320
Office (757) 424-8515
Fax (757) 424-8348
Cell (804) 432-4725
Sarah.Stansberry@DBHDS.Virginia.gov

SVTC
Debra A. Smith
Community Integration Manager
DBHDS, Division of Developmental Services
SVTC
PO Box 4030
Petersburg VA. 23803-0030
Office (804)-524-7897
Fax (804)-524-7643
Cell (804) 840-0978
Debbie.Smith@DBHDS.Virginia.gov

SWVTC
Michele Laird
Community Integration Manager
DBHDS, Division of Developmental Services
SWVTC
P.O. Box 1328
Hillsville, VA 24343
Office (276) 728-1133
Fax (276) 728-1103
Michelle.Laird@DBHDS.Virginia.gov

Who is my Community Resource Consultant?

Community Resource Consultants (CRCs) provide training and technical assistance to CSBs, private providers, family members and individuals to ensure the best possible decisions are made regarding individuals' supports in the community. There are ten CRCs located across Virginia. Your CRC provides training, consultation, attends your pre-move meetings if needed and completes post-move moving visits to your community providers after your discharge to make sure that you are receiving quality, person-centered services.

Community Resource Consultants

Gail Rheinheimer
Community Resource Manager
Training and Technical Assistance
PHONE: (540) 981-0697
FAX: (540) 857-6109
gail.rheinheimer@dbhds.virginia.gov

Region 1 Central Virginia Training Center	**Region 2 Northern Virginia Training Center**	**Region 3 Southwest Virginia Training Center**	**Region 4 Southside Virginia Training Center**	**Region 5 Southeastern Virginia Training Center**
Eric Williams	**Barry Seaver**	**Wanda Earp**	**David Meadows**	**Xiomara Apicella**
DBHDS Catawba Hospital 5525 Catawba Hospital Drive Catawba, VA 24070 (540) 375-4248 (540) 375-4224 (Fax) eric.williams@dbhds.virginia.gov	DBHDS P.O. Box 1797 Richmond, VA 23218-1797 (804) 286-9008 (804) 286-9011 (Fax) barry.seaver@dbhds.virginia.gov	DBHDS 870 Bonham Road Bristol, VA 24201 (276) 669-7762 (276) 669-3306 (Fax) wanda.earp@dbhds.virginia.gov	DBHDS Central Office P.O. Box 1797 Richmond, VA 23218-1797 (804) 786-5813 (804) 786-5855 (Fax) david.meadows@dbhds.virginia.gov	DBHDS P.O. Box 6243 Portsmouth, VA 23703 (757) 434-5328 (757) 484-4047 (Fax) xiomara.apicella@dbhds.virginia.gov
Harrisonburg-Rockingham Northwestern Rappahannock-Rapidan Valley	Arlington Middle Peninsula-Northern Neck* Prince William Rappahannock Area* *outside region	Alleghany Highlands Blue Ridge Cumberland Highlands New River Valley	Hanover Henrico Richmond Southside	Eastern Shore Portsmouth Virginia Beach Western Tidewater
Kathy Witt	**Jen Kurtz**	**Karen Poe**	**Andrea Coleman**	**Michelle Guziewicz**
DBHDS 120 Tremough Drive Wytheville, VA 24382 (276) 223-3723 (276) 223-3295 (Fax) kathy.witt@dbhds.virginia.gov	DBHDS P.O. Box 1797 Richmond, VA 23218-1797 (804) 461-0256 jennifer.kurtz@dbhds.virginia.gov	DBHDS 115 Wilkinson Drive Hillsville, VA 24343 (276)733-5176 (276)728-3745 (Fax) karen.poe@dbhds.virginia.gov	DBHDS Central Office P.O. Box 1797 Richmond, VA 23218-1797 (804) 371-2583 (804) 692-0077 (Fax) andrea.coleman@dbhds.virginia.gov	DBHDS P.O. Box 1797 Richmond, VA 23218-1797 (804) 286-9008 (804) 286-9011 (Fax) michelle.guziewicz@dbhds.virginia.gov
Central Virginia Region 10 Rockbridge	Alexandria Fairfax-Falls Church Loudoun	Danville-Pittsylvania Dickenson Mt. Rogers Piedmont Planning District 1	Chesterfield Crossroads District 19 Goochland-Powhatan	Chesapeake Colonial Hampton-Newport News Norfolk

Who is my Licensing Specialist?

Contact the Office of Licensing in the central office via phone at (804) 786-1747 and your call will be referred to the best source to address your issue.

Who is my Human Rights Advocate?

Location	Advocate	Phone	Fax	Toll Free
NVTC	Kevin Paluszak, Regional Advocate	703-323-2098	703-323-2110	877-600-7431
SWVTC	BJ McKnight	276-728-1111	276-728-1118	
SVTC	LaDonna Walters	804-524-7431	804-724-7398	
SEVTC	Stewart Prost	757-424-8263	757-424-8348	
CVTC	Beverly Garnes, Regional Advocate	804-524-7479	434-947-6274	866-645-4510
CVTC	Joan “Beth” Lee	434-947-6230	434-947-6343	

Who is my MFP Family Resource Consultant?

Betty Vines
MFP Family Resource Consultant
(804)786-0618 (office)
(804)240-0180 (cell)
betty.vines@dbhds.virginia.gov

Who are important contacts for Developmental Services at DBHDS?

Lee Price
Director of Office of Developmental Services (ODS)
(804)786-5850
lee.price@dbhds.virginia.gov

Heidi Dix
Asst. Commissioner of Developmental Services
(804)786-3921
heidi.dix@dbhds.virginia.gov

MFP Provider Selection Guide

What is the MFP Provider Selection Guide and how will it help in my transition?

Money Follows the Person (MFP) has assembled information from various sources to aid in the decision making process regarding residential supports for individuals transitioning to homes in the community. This shortened version has been created to use as a guide to discuss various topics or concerns that families/guardians will have while screening potential residential services providers. Please remember every individual will require their own set of supports so you may have to go into more detail with your questions or concerns. Feel free to modify this guide to meet the specific needs of your loved one as you begin your selection process.

What are some of the topics or issues I need to cover when screening potential residential services providers?

- **Section I – Provider Information:**

  Local & corporate – name, address, telephone number, contact person & title

  Licensure info – number of years in business, length of current certification, suspensions, revoked

  Homes – number operated by organization & locations

  Type of organization – for profit, not-for-profit, partnership, sole proprietorship, etc.

  Philosophy – mission statement of organization, philosophy of supports

- **Section II – Residential & Individual Information:**

  Appearance of home – well kept, clean, free of hazards, smell, adequate space, comfortable space, single level (if needed)

  Safety – fenced yard, front & back, type of locks on doors, alarms, safety rails, ramps, plan to keep individuals safe, evacuation process, smoke alarms, entries & exits (easily accessible)

  Individuals – number, age range, sex, special needs, appearance, cleanliness, interactions with individuals and staff, personal items, grievance policies

  Kitchen – adequate equipment and safety precautions

  Bedrooms/Baths – private or shared and number, individual/families decorate

  Modifications - wheelchair accessible (if needed)

Laundry room – where located, easily accessible, persons responsible for laundry, individuals encouraged to participate

- **Section III – Program & Transportation Information:**

  Visits & vacations – policies on visits & telephone calls from families/guardians, announced or unannounced, overnight trips to visit families/guardians, vacations away from residence, length of stays

  Person centered practices – personal choice in development & implementation of support plan, age appropriate, unique needs identified

  Oversight – management reviews, procedures for handling problems with staff, grievance policies, supervision, monitoring

  Activities – planning for community involvement, access to desired house of worship, personal interests, daily/weekly schedules

  Transportation – types, distance to day support and employment, safety, costs, arrangements, repairs

  Disagreements – policies on handling problems between individuals and staff

- **Section IV – Financial Information:**

  Costs - services covered (food, cable, private phone), funding for program, resources, medical expenses, upkeep of specialized equipment, supplies, communication with families/guardians regarding finances

  Individual – policies on handling personal finances, incidental amounts, purchases for personal care items and clothing, payee for disability benefits

- **Section V – Staff Information:**

  Knowledge/Skills/Abilities – requirements for direct support professionals, initial and ongoing training, training to handle complex medical needs & positive behavior support plans, sign language, autism expertise, skilled nursing

  Staffing – individual/staff ratio per shift, average tenure of staff, policies for emergency coverage with open shifts, ability to provide proper supports, onsite supervision, overnight staffing

  Communication – types to relay changes & updates in medications & diets, info about individuals, schedule changes

  Work relationships – interactions with other individuals, co-workers, management

- **Section VI – Day Support, Employment & Education Information:**

Day support – requirements, location, visit

Employment – requirements if individuals are capable, number of individuals employed, job skills training

Education – school requirements if applicable, location, class set up, ratio of teachers to students, related services (therapies), connections with local colleges or universities

- **Section VII – Medical Information:**

Medicines – qualifications to administer, training, storage location, security, nurse monitoring

Medical care – physical exams, dental care, psychiatric care, etc., locations, annuals

Emergencies – policies, 911, communication with families/guardians, staff coverage, hospitals

- **Section VIII – Nutrition Information:**

Food - accessibility, refrigerator/freezer adequately stocked, pantry/cabinets adequately stocked, favorite foods/beverages of individuals

Preparation – special diets, cooking, frozen vs. fresh foods, recipes, individual involvement

Menus – nutritious & well balanced, visibility of menus, planning, staff & individual input, weekly or monthly

Kitchen – adequate equipment & appliances, modifications, safety issues

Costs – allocation of funds for meals & snacks, food budgets, shopping, dietician or nutritionist services available

- **Section IX – Community/Social Events Information:**

Community – neighborhood & community /social activities, interactions with neighbors

Events – staff and individual input/choices for planning special events, parties, religious activities, independent or group events, activity calendars

- **Section X – Family/Guardian Involvement:**

Communication – open lines of communication with families/guardians, sudden illnesses or problems

Support plan – families/guardians involvement with support plan, level of support required, families/guardians involvement with major decisions such as medical care, behavioral issues

Problem areas – policies on handling conflict with provider or staff, areas of concern, grievance policies

Legal guardianship – assurance new residence is aware of legal guardianship roles in decision making

Additional Resources

Where can I find additional resources to help me transition to my new home in the community?

Visit http://www.dbhds.virginia.gov/ODS-default.htm for more information on the following resources that will help in your transition to your new home in the community:

Family Mentor Network of Virginia

This program has been developed for families and persons with disabilities as a resource for assistance. The network is comprised of volunteers familiar with the developmental and intellectual disability services system, is local to the community, and can be called upon for support in the efforts to identify and obtain needed information.

In an effort to provide needed support, Family Mentors are matched with families that are struggling with the idea of their loved ones transitioning to the community. Mentors share what they have learned through training and their own life experience, with families in their communities. We believe that families are the experts on their family members with disabilities and that sharing this expertise benefits all. It is our goal through the Family Mentor Network to gather information about needs and services that is family-friendly and improves the lives of people with disabilities and their families.

This program is confidential and volunteers are available to support families by request. If you are interested in becoming a mentor or request the services of a mentor, please contact Betty Vines, FRC (information included in DBHDS Contact Information).

New Beginnings Video (Coming Soon)

This video highlights success stories of women who have transitioned successfully to the community under the Money Follows the Person (MFP) project. The first video, “My Life – A New Adventure,” highlighted success stories of men who transitioned successfully to the community and is available on the website. We will continue to add new videos sharing success stories as more individuals continue to make the transition to community living. To view current videos, visit http://www.youtube.com/user/ODSMyLifeVideo.

Alone we can do so little; together we can do so much.

Helen Keller

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services